Administered by:

AlwaysCare℠

Dental & Vision Insurance Application *for Individuals*

Please be sure to read all information fully and sign where indicated on back.
Send no money. Once approved, your policy and ID card will be mailed or emailed to you.

Underwritten by: Starmount Life Insurance Company
8485 Goodwood Boulevard • P.O. Box 98100 • Baton Rouge, LA 70898-9100 • 1-888-729-5433

To Be Completed by Applicant:

Applicant's Name: ______________________________ ❑ Male ❑ Female
Last First Middle Initial

Applicant's Address: ______________________________
Street or Post Office Box Apartment Number

City: ______________ State: ______ Zip: __________ Date of Birth : _____/_____/_____
(mm/dd/yyyy)

Last 4 Digits of Applicant's Social Security Number: ___ ___ ___ ___ Email Address: ______________

Home Telephone Number: (_______)______________ Cell or Work Number: (_______)______________

Name of Spouse (if to be insured): ______________________________
Last First Middle Initial

Date of Birth (mm/dd/yyyy): _____/_____/_____ ❑ Male ❑ Female

Select Coverage:

❑ Individual ❑ Individual & Spouse (in HI, or Reciprocal Beneficiary) ❑ Individual & Children ❑ Individual & Family

Select Plan Option:

❑ Value ❑ Standard ❑ Preferred

Select Waiting Period:

❑ 12 Month Waiting Period ❑ No Waiting Period

Indicate Method of Payment (Checking account deduction or credit card payment only):

❑ Deduct premium payments from my checking account automatically. (My voided check is enclosed.)

❑ Charge future payments to: ❑ VISA ❑ MasterCard

Credit Card Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Expiration Date (MM/YY): ____/____

I Want to Pay:

❑ Every Month ❑ Every 3 Months ❑ Every 6 Months ❑ Every 12 Months

To Be Completed on Each Dependent Child to be Insured:

CHILD'S NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH (MM/DD/YYYY)	GENDER	RELATIONSHIP*	CHECK IF:
		❑ Male ❑ Female	❑ Daughter ❑ Son ❑ Stepdaughter ❑ Stepson ❑ Other ________	❑ Handicapped Child ❑ Full-Time Student
		❑ Male ❑ Female	❑ Daughter ❑ Son ❑ Stepdaughter ❑ Stepson ❑ Other ________	❑ Handicapped Child ❑ Full-Time Student
		❑ Male ❑ Female	❑ Daughter ❑ Son ❑ Stepdaughter ❑ Stepson ❑ Other ________	❑ Handicapped Child ❑ Full-Time Student
		❑ Male ❑ Female	❑ Daughter ❑ Son ❑ Stepdaughter ❑ Stepson ❑ Other ________	❑ Handicapped Child ❑ Full-Time Student

* RELATIONSHIP - If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered attach a copy of the order.

Do You have any other dental insurance in force with another company? ❑ Yes ❑ No
Is this insurance intended to replace any other insurance now in force? ❑ Yes ❑ No

APPLICATION CONTINUED ON OTHER SIDE. PLEASE READ, SIGN AND DATE WHERE INDICATED.
For questions call 1-888-729-5433 ext. 2013

Applicant's Statements and Agreements:

1. I understand that the effective date of the policy will be the date recorded in the Policy Schedule of Benefits by Us.
2. I understand the policy I am applying for contains different Waiting Periods for certain benefits listed in the Policy Schedule of Benefits. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the effective date of coverage.
3. I understand that (in MT, unmarried,) dependent children, if any, will be covered until the end of the month following their (in LA and MS, 21st birthday; 24th if full-time students) (in AL, AR, CT and UT, 26th birthday) (in ID, KY, MO, MT, NM, TX and WV, 25th birthday) (in KS, 19th birthday; 23rd if full-time students) (in OH, 19th birthday; 28th if full-time students) (in AK, CO, DE, DC, HI, IA, MI, NV, OK, OR, RI and WY, 19th birthday; 24th if full-time students) (in SC, 19th birthday) (in IL, 26 [30 if a military veteran and Illinois resident]) (in TN, 24th birthday) (in WI, over 17, but less than 27 and meets Wisconsin's eligibility requirements for dependents).
4. I understand that: (a) Starmount Life Insurance Company is not bound by any statement made by me, the applicant, or any associate/agent of Starmount Life Insurance Company unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy together with this application, endorsements, benefit agreements and riders, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Our president and secretary, and noted in or attached to the policy.
5. I acknowledge receipt of, if applicable: ❑ Outline of Coverage.

Notice of Information Practices:

To issue an insurance policy, We may need to obtain additional information about You and any other persons proposed for insurance. Some information will come from You and some may come from other sources. That information and any other subsequent information collected by Us may in some circumstances be disclosed to third parties without Your specific consent. You have the right to access and correct the information collected about You except information that relates to a claim or to a civil or criminal proceeding. If You wish to have a more detailed explanation of Our information practices, please submit a written request to Us. This notice applies only in Arizona, California, Georgia, Illinois, Maine, Minnesota, Montana, Nevada, North Carolina, Oregon and Virginia.

Authorization to Obtain Information:

I authorize the following to give information (defined below) to Starmount Life Insurance Company or any person or group acting on their part: any medical professional, any medical care institution, insurer, reinsurer, government agency, consumer reporting agency or employer. "Information" means facts of a medical nature in regard to my physical or mental condition, employment, or other insurance coverage, or any other nonmedical facts. I understand that this information will be used by Starmount Life Insurance Company to determine eligibility for insurance and may be used to evaluate a claim for benefits during the time it is valid. I agree that this authorization is valid for 30 (24 months in AK, KS, KY, OK, NM, WV and WY) months from the date signed. (In AK, I also understand that I may revoke the authorization at any time by a written request to Us.) (In WY, I understand that I may revoke this authorization at any time, by written request.) I know that I have a right to receive a copy of this authorization upon request. I agree (in KY, and represent) that a copy of this authorization is as valid as the original.

I understand that the premium amount listed on this application represents the premium amount that either my employer will remit to Starmount Life Insurance Company on my behalf, or I will remit directly to them. I further understand that this amount, because of my employer's billing/ payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.

I also understand that if I am receiving any Medicaid benefits, the purchase of this coverage may not be necessary.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Starmount Life Insurance Company Policy. I have read, or had read to me, the completed application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
In Kentucky, any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

(In Utah): **The policy provides limited benefits. The policy provides dental and [vision] benefits only. Review your policy carefully.**

Signed and Dated at _____ on _____/_____/_____
City and State Date

Applicant's Signature: _____

Associate/Agent's Printed Name: _____ **Signature:** _____ **Date:** _____

General Agent (if applicable): _____